Medicare Prescription Drug Coverage Worksheet

1.	What is your name as it appears on your Medicare card?	MEDICARE HEALTH INSURANCE					
2.	What is your Medicare Claim Number?	① JOHN L SMITH					
3.	What is your date of birth?	Medicare Number/Número de Medicare 2 1EG4-TE5-MK72 Entitled to/Con derecho a 3 HOSPITAL (PART A) 4 MEDICAL (PART B) 03-01-2016					
	Month/Date/Year						
4.	What is the coverage start date for your Medicare?						
	® _{Part A}	Part B					
5.	Month/Date/Year What is your Zip Code?	<i>Month/Date/Year</i> County?					
	Address, City, State						
	Phone #						
	*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.						
6.	Check the ONE box that best describes your INCOME .*						
	Single, widowed, divorced or live apart from my spouse and:	l: Married and:					
	My annual gross income is less than \$19,140	Our annual gross income is less than \$25,860					
	My annual gross income is greater than \$19,140	Our annual gross income is greater than \$25,860					
7.	Check the ONE box that best describes your LIQUID ASSETS . Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*						
	Single, widowed, divorced or live apart from my spouse and	d: Married and:					
	☐ My assets are \$14,800 or less	Our assets are \$29,160 or less					
	☐ My assets are greater than \$14,800	Our assets are greater than \$29,160					
8.	What is the name of your current Medicare Prescription Dru	rug coverage?					

SHICK Counselor Name: Telephone: Telephone: I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 2021 to December 7, 2021. Talso understand the costs and covered medications quoted on the plan I've chosen may be subject to change Signature: Printed Name:	and your monthly cost). PLEASE PRINT CLEA	ARLY. ATTACH AN	I EXTRA SHEET IF NEEDED.				
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SHICK Counselor Name: Telephone:	8. List the pharmacy or pharmacies you use. (Required)						
SHICK Counselor Name: Telephone:							
have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan:	SHICK Disclaimer						
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Signature:Printed Name:	I also understand the costs and covered medi	cations quoted o	on the plan I've chosen ma	y be subject to change			
	gnature:Printed Name:						
	Date:						

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month